to exert a programming effect if—as seems likely—such an environmental mechanism exists. This in turn directs attention to the potential role of the fetal supply line, and placentation in particular, which is known to play an important part in determining variation in growth between twin pairs and also singletons.[13] The comparatively large effect seen in within pair analyses relative to singletons suggests that discordance in birth weight within multiple pregnancies may be more closely related to the underlying mechanisms of fetal programming than is birth weight variation between unrelated singletons.

These data from twin studies should encourage a more critical approach to the debate about the public health implications of the fetal origins hypothesis as well as to the underlying mechanism. Striving to improve the nutritional status of girls and young women is undoubtedly desirable. However, whether this holds the key to the primary prevention of coronary heart disease and non-insulin dependent diabetes is far from clear—even though the basic propositions of the fetal origins hypothesis look like they may well be correct.

David A Leon *reader in epidemiology*
London School of Hygiene and Tropical Medicine, London WC1E 7HT (d.leon@lshtm.ac.uk)

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Managing the clinical performance of doctors

A coherent response to an intractable problem

The last few years have seen a progression of "rogue doctors" and health care scandals through the media.[1] Now, unsurprisingly, we have a series of proposals that attempt to guarantee to patients that the doctors treating them are up to standard. Public confidence must be restored, or trust in the National Health Service will be destroyed. Three weeks ago the prime minister launched the Commission on Health Improvement (CHI), which will inspect health services in England and Wales and respond to services in trouble.[2] Two weeks ago the General Medical Council discussed its proposals for revalidation for every doctor in the United Kingdom.[3] Now the chief medical officer of England has issued his proposals on how poor clinical performance among doctors will be prevented, recognised, and dealt with.[4] The old system—based on an expectation that professionals would keep up to date and do something about poorly performing colleagues combined with some half hearted systems of self regulation—is dead.

Nobody can deny that there is a problem. "Bristol"—the case of poor performance in paediatric cardiothoracic services—heads the list and, I have argued, changed everything.[5] But there have been several other episodes, and chillingly the chief medical officer seems to accept there are more to come: "We expect that over the next three to five years, an increasing number of incidents will surface as local services begin to 'declare' longstanding problems that have not been addressed." Medicine—and not just in Britain[6 7]—has a culture of hiding errors and forgiving those who make them. This stems not only from professional tribalism and a feeling that "there but for the grace of God go I" but also from doctors knowing that they simply cannot do much of what patients want and even expect them to do.[8]

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England's chief medical officer, Liam Donaldson, knows about the culture of turning a blind eye because he has contributed to a book that enlarges on the theme.[7 9] He has also published a study in the *BMJ* showing that 6% of senior doctors in the NHS had a performance problem in a five year period.[10] Furthermore, he found himself caught up in a long running dispute in Gateshead that led to questions in parliament and a government inquiry—so he knows first hand the deficiencies in the present system.[11]

The report gives the impression that the government has considered the possibility of ending self regulation. It's not only for doctors that self regulation has been questioned. The press, for instance, does a poor job—but is unlikely to be reformed because it's much more important and threatening to politicians than doctors are. A government task force on better regulation has been looking at all forms of self regulation and has concluded that overall it does have some benefits.[12] But the chief medical officer's report qualifies its support for self regulation by saying that it will continue "if such arrangements can be modernised to offer patients appropriate protection." General Medical Council and royal colleges be warned.

Donaldson's main recommendation for preventing poor performance is appraisal for all doctors in the NHS. Appraisal may sound scary to those who have

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never experienced it, but it is thoroughly familiar to most workforces—including that of the BMA. Appraisal provides an opportunity to give individuals feedback on their performance, chart their continuing progress, and discuss training and career development. It's also an opportunity, although the report doesn't make this clear, for employees to feed back on their boss's performance and how their job conditions could be improved. Once you've experienced appraisal you wonder how you did without it. The report also says that the NHS executive is to develop a policy for addressing the needs of sick doctors. This is long overdue. Every employer has an obligation to help sick employees, and the NHS has so far done a dismal job. Resources will be needed but are not mentioned.

Elaborate mechanisms to deal with poor performance are no use if those who are performing poorly cannot be identified. The report seems to hope that appraisal will be the main mechanism but also proposes a review of many methods that are used in other countries, including credentialling; use of simulators; regional, national, and international audits; and primary care detection schemes. More work is needed here.

Some of the main difficulties in implementing the report may come from the proposal to replace current disciplinary procedures, including the current right of consultants to appeal to the Secretary of State. The report proposes the creation of "assessment and support centres" which would "provide both impartial support to the local employer by advising on the action to be taken and an environment supportive to the doctor undergoing assessment." The action to be taken might range from a return to work without supervision through to referral to the GMC. The centres would cover all doctors, including general practitioners, and would have "a medical director and a board of governors with a lay chairman." The report intends "that referral [to a centre] would not carry any public stigma." Surely, a huge cultural change will be needed before that could ever be the case.

These proposals are unlikely to be greeted with enthusiasm. They may be seen as boiling down to "less freedom, more management"—but management is essential in increasingly complex systems. The chief medical officer's proposals are impressively coherent and surely hold the possibility of making progress with this intractable but important problem. Many doctors will be wondering how NICE (the National Institute for Clinical Excellence), CHI, clinical governance, audit, appraisal, revalidation, and assessment and support centres are all intended to fit together, and the report explains the overall pattern well. Nevertheless, there must be an anxiety that a plethora of new mechanisms may not work any better than the old mechanisms, many of which were ignored. Presumably the government hopes that the various big sticks that are included in the package will be enough to command the attention of doctors—but what is needed most is a culture change. We need a culture that allows doctors to express fears, doubts, and vulnerabilities; identifies and helps those in difficulties; refuses to condone inappropriate delegation; values teamwork and continuous learning and improvement; and genuinely puts the interests of patients first. The "Newcastle mafia" of Donaldson, Donald Irvine (president of the GMC), and George Alberti (president of the Royal College of Physicians of London) are all promoting cultural change. So perhaps something will happen.

Richard Smith *editor, BMJ*

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Sexual and reproductive health: what about boys and men?

Education and service provision are the keys to increasing involvement

Boys and men have been left out in our efforts to improve sexual and reproductive health. A national survey of family planning clinics by the Family Planning Association showed that young men are much less likely than women to access sexual health services.[1] The United Kingdom government is currently assessing the feasibility of a screening programme for *Chlamydia trachomatis*. Its two pilot studies are focusing on women, but some argue that this "calls into question our ability and commitment adequately to address the sexual health needs of heterosexual men."[2] Why should we turn our attention to men? And how can we foster men's responsibility towards sexual and reproductive health? These questions were considered recently at the fifth seminar of the European Society of Contraception in Amsterdam and several proposals made.

Objections were raised to focusing on men's needs, including the concern that this may jeopardise reproductive health services for women and that men already have too much power over decisions affecting women's fertility and sexual health. Nevertheless, increasing evidence exists that ignoring the sex education and sexual health needs of young men has important and wider social and health consequences.

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